TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Baylor Surgical Hospital at Trophy Club

Respondent Name
New Hampshire Insurance Co

MFDR Tracking Number
M4-17-1160-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
December 28, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The total reimbursement per Medicare fee schedule is $7,757.69."

Amount in Dispute: $1,193.69

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "While the provider did submit a certification statement with the MFD Request, ForeSight believes its recommendation of $3,500.00 is fair and reasonable..."

Response Submitted by: Foresight, 1408 Westshore Blvd, Suite 1010, Tampa, Florida 33607

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 29, 2016	Outpatient Hospital Services	$1,193.69	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient hospital services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - A19 – Upon further review, additional payment is warranted
   - W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal

- 370 – This hospital outpatient allowance was calculated according to the APC rate, plus a markup
- 885 – Review of this code has resulted in an adjusted reimbursement
- C19 – Charges for surgical implants are reviewed separately by Foresight Medical Direct inquiries regarding surgical implants to 813-930-5346
- P12 – Workers' compensation jurisdictional fee schedule adjustment
- 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service
- P13 – Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies
- 790 – This charge was reimbursed in accordance to the Texas Medical fee guidelines

Issues

1. What rule applies to reimbursement?
2. What is the maximum allowable reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requester seeks additional reimbursement of $1,193.69 for outpatient hospital services rendered on March 29, 2016.

   The requestor states, "The total reimbursement per Medicare fee schedule is $7,757.69." The respondent states, "…no further allowance is due."

   As both positions are related to the appropriate fee, this review will consider the applicable fee guideline found in 28 Texas Administrative Code §134.403, "Hospital Facility Fee Guideline--Outpatient."

   The relevant portions are:

   > (b) Definitions for words and terms, when used in this section, shall have the following meanings, unless clearly indicated otherwise
   >
   > > (3) "Medicare payment policy" means reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.
   >
   > (d) For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section, including the following paragraphs.
   >
   > (f) The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
   >
   > > (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
   > >
   > > > (A) 200 percent; unless
   > >
   > > > (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent.

   The calculation of the maximum allowable reimbursement if found below.

2. The Medicare payment policies used to calculate the MAR are found at, www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS.

The resources that define the components used to calculate the Medicare payment for OPPS are found below:

- **How Payment Rates Are Set**, found at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/HospitalOutpaysysfctsht.pdf,
  - *To account for geographic differences in input prices, the labor portion of the national unadjusted payment rate (60 percent) is further adjusted by the hospital wage index for the area where payment is being made. The remaining 40 percent is not adjusted.*

- **Payment status indicator** - The status indicator identifies whether the service described by the HCPCS code is paid under the OPPS and if so, whether payment is made separately or packaged. The status indicator may also provide additional information about how the code is paid under the OPPS or under another payment system or fee schedule. The relevant status indicator may be found at the following: www.cms.gov, Hospital Outpatient Prospective Payment – Final Rule, OPPS Addenda, Addendum, D1.

- **APC payment groups** - Each HCPCS code for which separate payment is made under the OPPS is assigned to an ambulatory payment classification (APC) group. The payment rate and coinsurance amount calculated for an APC apply to all of the services assigned to the APC. A hospital may receive a number of APC payments for the services furnished to a patient on a single day; however, multiple surgical procedures furnished on the same day are subject to discounting. The relevant payment amount for each APC may be found at: www.cms.gov, Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Annual-Policy-Files, Addendum B. These files are updated quarterly.

Review of the submitted medical claim finds a request for separate reimbursement of implantables. The services in dispute will be reviewed per the 28 Texas Administrative Code § 134.403 (f)(1)(B).

Procedure Code	Status Indicator	APC	Payment Rate	60% labor related	2016 Wage Index Adjustment for provider 0.8223	40% non-labor related	Payment	Maximum allowable reimbursement
C1762	N	**See below**						
29881	T	5122	$2,395.59	$2,395.59 x 60% = $1,437.35	$1,437.35 x 0.8223 = $1,181.93	$2,395.59 x 40 =$958.24	$1,181.93 + $958.24 = $2,140.17	$2,140.17 x 130% = $2,782.22
							Total	$2,782.22

Status Indicator **N** has the following definition – "Items and Services Packaged into APC Rates. Paid under OPPS; payment is packaged into payment for other services. Therefore, there is no separate APC payment."

Separate reimbursement for the implantable was requested however, the submitted code on the claim line associated with the implant is packaged based on the status indicator.

3. The total allowable reimbursement for the services in dispute is $2,782.22. This amount less the total paid by the insurance carrier of $6,564.00 leaves an amount due to the requestor of $0.00. No additional reimbursement recommended.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		February 8, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.